Alcohol relapse and near-relapse experiences show that relapse models need to be updated

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Published in:
Alcoholism Treatment Quarterly

DOI:
10.1080/07347324.2018.1532775

Publication date:
2019

Document version
Accepted manuscript

Citation for published version (APA):

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Download date: 18. Apr. 2021
Title: Alcohol relapse and near-relapse experiences show that relapse models need to be updated

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Short title: Experienced differences between relapse and near-relapse.
Abstract

Why do people with Alcohol Use Disorder [AUD] frequently relapse after completing treatment? This study examines the experience of relapse compared to near-relapse, thereby illustrating the difference between relapsing and staying abstinent when faced with a high-risk situation. Through twelve qualitative interviews and subsequent Interpretive Phenomenological Analysis, we found that the experiences could be understood in terms of two themes: a) regulation of self, and b) the role of other people. Relapse specifically was characterized by the use of alcohol as a means of self-regulation combined with the sense of being disconnected from other people. The implications are that current relapse models need to place more emphasis on the interpersonal aspects of relapsing. The implications for practice are that AUD patients should be assisted in building new and/or strengthening existing ties to social networks.

Keywords: alcohol use disorder (AUD), relapse, near-relapse.
Introduction

Alcohol Use Disorders (AUDs) are widespread throughout Europe and North America (Grant et al., 2004; Jürgen et al., 2015), and are among the most disabling disease categories in the Global Burden of Disease (WHO, 2012). In the treatment of AUD patients, long-term relapse prevention has been identified as the biggest challenge (Mann & Hermann, 2010). The aim of this article is to illustrate how relapse and near-relapse are experienced through the perspective of the AUD patient.

AUDs are best treated as chronic and relapsing diseases (McLellan et al., 2000, McLellan et al. 2014). Treatment seeks to reduce alcohol use and related harms, such as physical and mental health problems, to improve quality of life, and reduce the frequency and severity of future cycles of use, often called “relapses” (Tiffany et al. 2012, Laudet 2011, McLellan et al. 2014). While treatment should not be considered a failure if an individual relapses, relapses often provoke a range of negative consequences – emotional, physical, social, and legal – and should be minimized for the sake of the individual’s long-term wellbeing.

A treatment which can effectively manage AUD is thus in the interests of both the individual and society in general. In spite of this, the disorder is often overlooked and untreated (Clay, Allen & Parran, 2008). Also, treatment today has only a limited effect (Cutler & Fishbain, 2005), with typical effect sizes for psychosocial treatments ranging from low to moderate (Martin & Rehm, 2012), and relapse rates between about 60% and 90% in the first year of treatment (Miller & Willbourne, 2002; Weiss, O’Malley, Hosking, LoCastro & Swift, 2008; Connors et al., 1996). The majority of relapses occur within the first month after alcohol cessation (Simioni et al., 2012), following typically short-term treatments of 1-3 months. Relapses would ideally trigger re-assessment and treatment entry (McLellan et al. 2007). Most often, however, relapses are the first step in another cycle of harmful, untreated alcohol use.

Research on relapse and near-relapse has mainly used a taxonomy developed by Marlatt and Gordon (1980). This taxonomy aims at clarifying the reasons behind relapses. It is comprised of two main categories of determinants - intrapersonal/environmental determinants and interpersonal determinants - under which there are a number of sub-categories. The taxonomy also provides the
foundation for the development of a cognitive-behavioral model of relapse (Marlatt & Gordon, 1980). Relapse prevention in treatment usually refers to this model. The model includes cognitive and behavioral approaches, which can be utilized depending on the point reached in the relapse process (Shand, Gates, Fawcett & Mattick, 2003).

However, this taxonomy has been criticized for its hierarchical structure and system of mutually exclusive determinants (Rubin et al., 1996; Hodgins et al., 1995). In response, a new version of the model has been proposed, which moves away from both the hierarchical structure and the mutually exclusive determinants (Witkiewitz & Marlatt, 2004). The new cognitive-behavioral model is still in need of further research before it can be used to increase understanding of onset and course of relapse (McKay et al., 2006). According to the authors, the cognitive-behavioral model should be treated as an empirical question thereby encouraging further research and revision of the model (Witkiewitz & Marlatt, 2005).

The model categorizes the different factors it contains according to their role in the relapse process. For this, factors are separated into either tonic processes or phasic responses, and into distal risks or proximal risks. Tonic processes indicate the individual’s chronic vulnerability to relapse. Part of the tonic processes are distal risks. The risks under this category, for example, lack of social support, are considered stable predispositions, which can increase risk of relapse. The phasic responses are the individual’s cognitive, affective and physical states and coping skills utilization, which are dependent on the specific situation. Finally there are proximal risks, which are factors that are immediate and actualizing precipitants of the relapse process (Witkiewitz & Marlatt, 2004).

One issue, brought forth by Stanton (2005), is that the cognitive-behavioral model does not treat interpersonal factors as proximal or phasic. Thus, the cognitive-behavioral model treats interpersonal factors as part of an individual’s chronic vulnerability to relapse, but without the ability to actualize relapses, despite research indicating that such factors play a central role (Leach & Kranzler, 2013). Conversely, intrapersonal personal matters are considered to be both proximal and phasic. Consequently, by favoring intrapsychic matters, such as self-efficacy and coping, Stanton argues that the model may overlook extent to which the social context influences the
relapse process.

To examine the relapse experience from the personal perspective of the involved patients, this study consists of qualitative interviews with former and current AUD patients. Participants were interviewed about two different experiences. The first was their most recent relapse experience. To examine what is unique to this experience, it was compared to a near-relapse experience, also called a relapse crisis (see e.g. Hodgins et al., 1995). This is a situation where relapse was imminent, but did not happen. By comparing these, this study will illustrate the difference between experiences where one uses alcohol and where one does not, as a response to a high-risk situation. Thus, this study examines the AUD patient’s own perspective on what is important when balancing between relapsing and staying sober.

**Methods**

**Procedure**

To recruit for this study, the first author contacted two alcohol treatment facilities that provided group treatment. One of these groups was managed by the public alcohol treatment facility, the other through volunteers who all had a history of alcohol abuse disorder. We contacted the public alcohol treatment facility because of its extensive access to AUD patients. Through this facility, access was gained to the other group, which largely consisted of patients the public treatment facility had previously been in contact with.

Facility staff then informed patients verbally of the study, and handed out a short information letter describing it as an independent exploration of relapse and near-relapse experiences. Patients were informed that non-participation would not impact their treatment in any way.

Recruiting of patients and interviewing took place from February to April 2017. The project leader carried out the interviews. Fourteen patients agreed to be interviewed, but two did not want to be recorded. These two were interviewed but only with the aim of increasing the researchers’ own understanding, and were not included in the analysis. The study was approved by the National
Committee on Health Research Ethics and the Danish Data Protection Agency. This study originated from a larger study, the RESCueH Programme (Nielsen et al., 2016; Roessler, Bilberg, Nielsen, Jensen, Ekstrøm & Sari, 2017).

**Participants**

Nine men and three women participated in the study. Ages ranged from 39 to 67 with an average of 55 years. One interview was completed with each participant. All were above 18 and Danish-speaking. One interviewee had no experience of either relapse or near-relapse. The interview was therefore not included in the analysis.

**The interview**

Interviewing took place in rooms made available by the treatment facilities. In both cases the rooms were adjacent to rooms used for treatment. Informed consent was obtained before any gathering of data. The interviews were semi-structured and lasted between 24-31 minutes. All interviews were recorded and transcribed verbatim. The interview schedule consisted of questions aimed at a) getting a general picture of the interviewee and their relation to alcohol abuse, and b) getting an understanding of their relapse and near-relapse experiences. The first questions concerned their own history with alcohol and were intended to establish rapport and to convey the researcher’s interest in the participant’s views and experiences. Thus, they were asked if they believed they had problematic alcohol use, and if so, when it started. Following this, participants were asked about their understanding of relapse.

The researcher then went on to ask if they could describe their last relapse experience: what had happened, and whether they remembered any particular thoughts and feelings they’d had before and during the relapse. Next, the same questions were asked about a near-relapse experience. Follow-up questions were prepared, for example: can you describe the day the relapse/near-relapse took place? Did you do anything specific on that day? Where were you when it took place? Were you alone or with other people? However, the follow-up questions were only used if deemed
constructive to the interview. This allowed the researcher some flexibility to probe areas of particular interest that arose during the interview (Smith, 1995). The focus in the interviews was not on what might have caused the relapse or near-relapse, but rather on getting rich descriptions of the experiences. To facilitate an interview characterized by spontaneous descriptions, questions that required causal reflections were not included in the interview schedule.

**Interviewing**

This was conducted face-to-face and guided by a phenomenological-hermeneutic approach. This approach is inductive and descriptive (Beck, 1994). With the aim of getting as close as possible to the experiential content of consciousness, the researcher strived to suspend previous judgments about the phenomenon of relapse, focusing instead on the experience, while treating all parts of the description as equally important (Smith et al., 2009). The approach also has a hermeneutic element. Here the centrality of actively engaging with the data through interpretation is emphasized, as the researcher is influenced by his/her own preconceptions (Koch, 1995). By acknowledging and working with one’s own preconceptions, the researcher can facilitate the coming forth of the phenomenon in focus, and gain an understanding of deeper and perhaps hidden meanings of what is expressed (Smith et al., 2009).

**Analysis**

The analysis of interviews followed the process of the interpretative phenomenological analysis (IPA) (Smith et al., 2009). IPA is based on the traditions of phenomenology, hermeneutics and idiography. IPA is suitable when studying important events in peoples’ lives, and the thoughts and feelings that can explain what the event means to the person. Since relapsing and near-relapsing were assumed to qualify as important events in the lives of the participants in this study, as they all either had or have alcohol use disorder, this approach was chosen. IPA has been used within the AUD and alcohol addiction field (see e.g. Emiliussen, Andersen & Nielsen, 2017; Shinebourne & Smith 2009, Toye, Williamson, Williams, Fairbank & Lamb, 2016).
To ensure validity, the themes were discussed between the authors. This was done by iteratively presenting interpretations to the other authors and, through this, achieving consensus on the formulation of themes (Stiles, 1993). Through the gathering and analysis of the interviews, the first author became aware of certain preconceptions he held about the relapse process. As the study progressed it became clear that his expectation regarding the study was that it would generally illustrate how intrapersonal processes, e.g. the individual making a certain choice for his/her own sake, were the lens through which the participant’s experiences would be best understood. In conducting this study, he became aware of this preconception inasmuch as understanding the relapse process conceived in terms of intrapersonal processes appeared inadequate. As the findings illustrate, a perspective which also included the social context was needed to capture the variation in the participants’ experiences.

**Description of the analysis process**

The analysis process used in this study has six steps, following the steps explained by Smith et al. (2009), with minor adjustments so that it fits with the current study’s aim of comparing the two experiences of relapse and near-relapse.

- **Reading of interview and gradual immersing in the data**: The interview was read several times over with focus on immersion in the data. The aim was to let the participant become the focus of analyses, and to gain an impression of the text as a whole.

- **Making initial notes in explorative fashion**: As the text began to make sense, the researcher began making notes in an exploratory fashion. The notes contained descriptions, impressions, and generally anything of interest, including reflections of a more conceptual nature. As this step increased familiarity with the text, the researcher started to use the distinction between relapse and near-relapse.

- **Creation of emergent themes**: The text was then re-read, and a list was made containing all expressions relevant to either the relapse experience, near-relapse experience, or both. Then
emergent themes were developed. An emergent theme is a statement of what was important in a section of the interview. The researcher used mainly own notes, thus fragmenting the text, and on the basis of this created emergent themes, thus restructuring it again anew.

- **Creating superordinate themes:** Emergent themes were then grouped together in superordinate themes by rearranging them several times until a theme could be developed where as much complexity as possible was retained.
- **Repeating the process with other interviews:** This process was repeated with all interviews. The researcher’s aim was to treat each interview as unique.
- **Looking for patterns between themes from all interviews:** In the final step, a master list of themes for the relapse experience and near-relapse experience was created. References to the raw data were checked to ensure that themes matched participants’ own expressions.

**Findings**

The analysis showed how the experience of relapse and near-relapse could be understood as expressions of regulation of self and the role of other people. In total there were eleven subthemes, five derived from relapse experiences and six from near-relapse experiences. All quotations have been translated from Danish to English by the first author.

[insert table 1 here]

**Superordinate theme 1: The regulation of self**

The participants described how they tried to regulate emotions and behavior. In relapse experiences, they described how emotions seemed overwhelming and in an attempt to control them they used alcohol. However, some also described their awareness of how harmful drinking is. In order to switch perspective, they went into a reflective process which justified the drinking. Two
subthemes emerged. The first was *being overwhelmed by emotions*. Some put the experience of overpowering emotions in the context of a years-long emotional struggle, while for others the emotions were present for a shorter period of time, and lastly, for some, the emotions were experienced as the result of a particular, recent event. What was common to these experiences was that the emotions created a desire for the effects of alcohol.

“*Well, it is like, I’m just sitting there and thinking, I know I cannot drink, but I just have to drink this, and then just push the thoughts away [...] It’s like a vacation from my life*” (participant 6).

The subtheme illustrated how alcohol could serve the function of reducing an emotional burden. Drinking could therefore be seen as a way of regulating one’s mental wellbeing.

The second subtheme was *seeking justification for drinking*. Another aspect of the relapse experience was for some a reflective process, which ultimately led to the justification for drinking alcohol. The participants described giving themselves permission to drink alcohol, for example, with the justification that they were going to quit the following day.

“*And then, when I in fact relapsed, it was probably the thought, ‘well, you can just buy those four strong beers in Lidl, like, as I have always done. It doesn’t mean anything, because I’m going to quit tomorrow anyway’. But I couldn’t*” (participant 5).

By engaging in this process through which they changed their perspective, they regulated their view on their alcohol intake, making it more acceptable.

In contrast to this, the near-relapse experience was characterized by the awareness that in order to live the life they wanted, they could not drink alcohol. Also, they described being unable to rely solely on themselves to stay sober and therefore sought help. These experiences could be seen
as attempts to regulate one’s own emotions and behavior, where the relapse experience included alcohol intake whereas the near-relapse experience did not. In the near-relapse experiences, the regulation of the self also had two subthemes. First was knowing that the consequences of drinking on oneself are very serious. Some participants described how their knowledge of the effects of alcohol on them was a central part of their near-relapse experience. Examples of the effects of alcohol could be: depressing one’s mood, not living up to one’s own standards of a decent life, or simply making chances of survival low.

“It’s probably the fact that you have been used to having that emergency exit [...] I just know that I have this, that if I start drinking, I can’t stop. I know that the condition for me to live a decent life is me not drinking”

Interviewer: “And what is a decent life?”

“Well it is that you can just get up in the morning and have a day and take a shower and live your life” (participant 6).

Changing behavior so that one was able to live life in the desired way could be seen as a form of regulating one’s own behavior.

The second subtheme was knowing that seeking help is necessary. Some participants experienced impulses which they knew were too strong for them to control on their own. Knowing this, and on this basis reaching out to others for help, was an important element of their experience. Reaching out for help could take the form of contacting people, or voluntarily making legally binding promises to authorities.

“...my thought was, ‘I should definitely not relapse. I mustn’t. I am going to go in here and get Antabuse’ [disulfiram, a prescription alcohol-deterrent], because then I know that I cannot drink” (participant 1).
By seeking help from others, they managed to regulate their behavior in a way that prevented an actual relapse from taking place.

**Superordinate theme 2: The role of other people**

The participants described how other people played a central role in their experience of both relapse and near-relapse. The absence of other people was a central aspect of the relapse experience. Here, the participants described not playing a role in other people’s lives, nor having other people play a role in theirs. In the near-relapse experience, other people played a different role. There are still elements of absence, but also indications of acceptance of this absence. In addition, some participants described other people playing a central role in their lives, and themselves being a different person towards others.

In the relapse experience, three subthemes of the role of other people were found. The first was *not playing a role in other people’s lives*. Participants described that they wanted to play a positive role, including with their children, younger siblings or a partner. However, they shared that in whosoever’s life they wanted to play a role, they felt they were not playing it.

“Well, it was after all – this was after all what I wanted, you know. It was her that I wanted, and her two children that I wanted” (participant 5).

This theme reflects the participants’ difficulties in accepting the very modest degree to which they were involved in the lives of other people.

The second subtheme was *having no contact with people who understand you*. Some participants had contact with other people, whereas others had none. A central part of the relapse experience for people in both situations was that of not being understood by other people. This meant that other people could be physically present, but without understanding the participant.

“I don’t really talk to my friends anymore – once or twice a year, at most. Because
they don’t deserve the truth. I’m embarrassed by the truth.” (participant 10).

The third was a need for other people to set boundaries. Some participants experienced a loss of control over their actions as a consequence of being alone. In such situations, some had difficulty establishing and maintaining limits for alcohol intake. This wasn’t a case of missing contact with other people as such, but rather needing social boundaries to control their drinking. These social boundaries could, for example, come through living up to a certain work ethic:

“I never drank when I had to go to work. Neither did I drink at work. I drank too much when I came home from work, but not once did I drink so much that I had to call in sick because of it. Never. Then, when we were dismissed, my consumption started escalating. And finally, it went completely off the tracks.” (participant 7)

In near-relapse experiences, the role of other people had four subthemes, the first of which was missing other people. The near-relapse experience was for some characterized by the absence of other people, and the emotional pain associated with this. Participants described having this experience when, for example, comparing one’s own social life to what is displayed on social media, or when trying to handle difficult feelings, e.g. boredom and loneliness, alone.

“Rather than just going home and watching some television, or whatever I’m going to do, cook some food. Boredom, loneliness. Then it can come up” (participant 9).

This theme illustrates how the role of other people was, for some, as in the relapse experiences, characterized by its absence.

For other participants, the absence of other people was also coupled with an acceptance. This is illustrated in the second subtheme, which was an acceptance of being alone because this is necessary to stay sober. Some participants experienced feeling alone in the near-relapse experience.
They were, however, aware that their social lives were linked to alcohol in ways that they could not ignore. Some realized that in order to stay sober, they had to accept both being alone and the feelings of loneliness accompanying this. Thus, involved in the understanding of the dynamics of their social life was the decision that being alone, even though painful, was something one had to live with. The link between social life and alcohol consumption came for some in the form of social norms that were hard to stand up against, whereas for others, it was experienced as one’s own habits in social situations.

“And I don’t want to, how shall I put it?, dictate to an old friend, telling him that if I visit, you have to hide the bottles, and we won’t be having anything to drink. You don’t get to decide that, no of course I don’t. So I shall have to wait to visit until I feel ready for it, you see.” (participant 12).

Other participants did not experience the same absence of other people. They did, however, describe being aware, that their relationships were contingent on their continued abstinence. This was reflected in the third theme, a realization that close relationships are more important than alcohol. Knowing that drinking alcohol would cause their close contacts to abandon them, and realizing that these relationships meant more to them than alcohol, was what characterized the near-relapse experience for some participants. A person’s intimate social network may comprise romantic partners, friends and family, including grandchildren. For some, this also meant not engaging in other less close, alcohol-related relationships.

“My son – I want to be with him, damn it, I want to, when he has kids, then I want to be allowed to, then I want him to have enough trust in me to allow me to take care of those grandchildren. Take them to the Tivoli Gardens, or out for a walk in the forest, right, or be there for them if they have something they have to do. And if I’m not sober in my everyday life, then I lose that trust” (participant 2).
Thus, the mutually exclusive relationship that existed between alcohol consumption and close relationships was for some a central theme in their near-relapse experience.

The fourth subtheme was *knowing the effects alcohol has on one’s behavior towards others*. One participant described how abstinence was necessary for him to be able to live up to his responsibilities towards his family; another how she had been driving while drunk and how this memory was tormenting her because of the danger she put other people in. They shared the awareness in the near-relapse experience of how alcohol affected their behavior towards other people.

“Well, it was the first thought I had, because I have a son who lives with me, and he shouldn’t experience all the stuff that he… before he moved home to me” (participant 1)

**Discussion**

The aim of this article was to illustrate how the threat of relapse was experienced through the subjective perspective of the AUD patient. By comparing relapse experiences with experiences where the patient almost turned back to alcohol, this study illustrated how a relapse was characterized by using alcohol as a way of regulating oneself, coupled with the experience of being disconnected from other people. The findings thus indicated that both intrapersonal factors and interpersonal factors were characteristic of the relapse experience, which has both theoretical and practical implications.

Marlatt and Gordon’s taxonomy of relapse, in which reasons for relapse can be hierarchically divided into either environmental/intrapersonal or interpersonal (1980), provides one of the most widely used frameworks for understanding relapse and pre-emptively addressing these hypothesized reasons in a treatment setting. What this study illustrates is how the experience of relapse includes a
number of different themes of both interpersonal and intrapersonal character. We did not find that there was one predominant type of experience, or that one experience seemed to exclude all others. That there should be a hierarchy where some experience excludes others is therefore not supported by this study. On this basis, we agree with Hodgins et al. (1995), who noted that the taxonomy’s scoring rules seemed arbitrary. Instead, to capture the complexity associated with relapses, we recommend either moving away from Marlatt and Gordon’s taxonomy or revising the scoring rules.

With regards to the updated cognitive behavioral model of the relapse process (Witkiewitz & Marlatt, 2004), this study does not support the notion that interpersonal factors are only part of the individual’s chronic vulnerability for relapse, without the ability to actualize relapses (i.e. that interpersonal factors should be considered distal and tonic). Rather, it found that the role of other people was different in the relapse experience and the near-relapse experience, which indicates that social factors are neither stable predispositions, nor only part of a chronic vulnerability. Thus, this study illustrates how a relapse cannot be understood as an isolated action, but rather as one embedded in a social context.

Participants in this study echoed what has been reported in several qualitative and quantitative studies of AUD patients and polysubstance-using patients: loneliness and a lack of meaningful social connections are common throughout the treatment course (Litt et al. 2016, Muller et al. 2015, Muller et al. 2016, Roe et al. 2010, Güttinger et al. 2003). Some participants described how intentional isolation helped them in the near-relapse situation; for these participants, loneliness was the price they felt they had to pay for not relapsing. Similar intentional negotiations of social relationships have been reported among AUD and other substance use disorder patients (Brooks et al., 2017, Brown et al., 2015, Tracy et al. 2010). For other participants, loneliness cost them a relapse, a phenomenon also reported by numerous types of substance users (Laudet et al. 2004, Newton et al. 2009, Trombello et al. 2017). These participants connected their relapse experiences to loneliness, and described a need for more social connection to prevent future relapses. This study contributes to a complex understanding of isolation: described as both an intended action and an unintended situation, a positive protection and a negative risk. Nevertheless, while distancing
oneself from existing network members may be a successful technique to prevent relapse in the short-term by some, loneliness should not be clinically accepted as a requirement or side-effect of recovery in the long-term: population studies have shown loneliness to be a clear risk factor for mortality and morbidity population (Haukulinen et al. 2016, Holt-Lunstad et al. 2015).

Many researchers have begun differentiating relationships that provide specific support for recovery from those that provide other support but are ambivalent or even conducive to substance use (Tracy et al. 2010, Trombello et al. 2017, Stevens et al. 2015). Given the importance that participants in our study placed on accountable yet non-shaming relationships, it is clear that many AUD patients need assistance in accessing social networks that will support their recovery. The difference between a near-relapse experience and a relapse experience may be the presence of abstinence- or recovery-oriented support in the former, and the lack of such support – which may lead the patient to isolate themselves – in the latter. Such recovery-oriented support can be achieved through building new social networks and/or strengthening ties to existing network members, techniques which are developed through adjunct and outpatient therapies such as Network Support treatment for AUD patients (Litt et al. 2016), Social Behavioral and Network Therapy (Copello et al. 2006), Network Therapy (Galanter et al. 2014), and Peer Network Counseling for adolescents (Mason et al. 2015). These treatments could be added to standard AUD treatment and maintained as aftercare strategies (Day 2017). An example of an aftercare approach, which addresses relapse through peer-support, are the Collegiate Recovery Community (CRC) Programs (Harris, Baker, Kimball & Shumway, 2007). By addressing addiction in college and university settings, the CRC-model is intended to counter some of the challenges of staying sober under the combined pressure of trying to ‘fit in’ while in an environment with high rates of substance use (Laudet, Harris, Kimball, Winters & Moberg, 2015; Hingson, Zha & Weitzman, 2009). Though there is still need for more evidence on the outcome of CRC-programs, studies on relapse are encouraging (Laudet, Harris, Kimball, Winters & Moberg, 2014), suggesting relatively low relapse rates of 8% in a given semester (Harris, Baker, Kimball & Shumway, 2007).
Strengths and limitations

This study’s strengths include a rigorous and novel qualitative analysis technique of comparing recent relapse experiences to near-relapse experiences, and the participation of people in varying stages of recovery. Studies tend to separate patients into those who relapsed and those who didn’t, while our interest in near-relapse experience affords a more nuanced view. One limitation is that the participants were all part of a group-oriented psychosocial intervention, so their results may not be generalizable to those who seek out individualized forms of treatment. Cross-sectional interviews preclude determination of causation, but this does not weaken our findings of the consistent importance identified by participants of self-regulation and disconnection as defining elements of the relapse and near-relapse experience.

Conclusion

These findings demonstrate the utility of an inductive approach in interviewing to illuminate the complexity of the lives of AUD patients. The approach enabled us to identify a multitude of different themes, which shows how qualitatively examining relapses may provide useful knowledge, both theoretical and practical. Such inductive interviewing could even be used in clinical practice: relapses and near-relapses while in treatment, for example, could trigger a semi-structured interview by a treatment provider that seeks to understand the patient’s experience and identify risk factors for future relapse experiences.

The Authors declare that there is no conflict of interest.

This work was supported by the TRYG and Lundbeck foundations.
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<td>2) The role of other people</td>
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Table 1: Key themes and their associated subthemes